STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/29/2012

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BROOKDALE PLACE AT WILLOW LAKE LLC	2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268

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R0000	This visit was for a State Residential Survey. Survey dates: August 27, 28, 29, 2012 Facility number: 010234 Provider number: 010234 AIM number: N/A Survey team: Connie Landman, RN-TC Diana Zgonc, RN Census bed type: Residential: 54 Total: 54 Census payor type: Other: 54 Total: 54 Sample: 8 These State Residential findings are cited in accordance with 410 IAC 16.2. Quality review completed on September 5, 2012 by Bev Faulkner, RN	R0000	The following is the Plan of Correction for Brookdale Place of Willow Lake in regards to the Statement of Deficiencies for the annual survey completed on 8-29-2012. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted according to the facility policy and failed to ensure the fire department was included in fire safety for the facility. This had the potential to affect the entire facility of 54 residents. Findings include: A current facility policy, dated 8/15/2000, and titled "Fire and Disaster Plan" and	R0092	R 092 Administration and Management- (Non-compliance)What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?The alleged non-compliant practice was cited as having the potential to impact all of the community's residents.The fire department has been contacted in order to schedule a fire and disaster drill that will include the local fire department.The Executive	09/27/2012

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	provided by the Administrator on 8/29/12 at 10:25 A.M. indicated, "Policy--It is the policy ... to have a written Fire and Disaster Evacuation Plan ... which has the approval of the local fire department to be followed in the event of internal or external disasters for the care and safety of all residents and associates during emergency situations ... Procedure-- ... 5. Conduct fire and evacuation rehearsals on a monthly basis, quarterly per shift, maintaining records of date, participants, description and duration ... Review of the fire drills on 8/27/12 at 10:30 A.M., for the past year indicated only two fire drills had been completed on the 3rd (night) shift for the past 12 months, none since March, 2012. The records also lacked documentation any fire drills or safety training done in conjunction with the fire department for the past 12 months. Interview with the Administrator and Maintenance Director on 8/27/12 at 10:50 A.M., indicated he (Maintenance Director) had only been here for 4 months and did not know if the fire department had been included in the fire drills. He also indicated at that time, he didn't realize there were two night shift fire drills that had not been done.		Director/Designee has completed fire drills on all shifts according to policy. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? Residents and associates have the potential to be affected by the alleged deficient practice.The fire department has been contacted in order to schedule a fire and disaster drill that will include the local fire department.The Executive Director/Designee has completed fire drills on all shifts according to policy. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?A new Maintenance Director has been hired for the community. His training will include instruction on the procedure and documentation requirements for setting up fire and disaster drill according to existing policy.The Maintenance Director/Designee will be responsible for providing a schedule for fire drills as well as documentation of any fire drill scheduled with the local fire department to the Executive Director. Documentation of completed fire drills will be kept in a binder, and available for review by the Executive Director/Designee at all times. How will the corrective actions be monitored to ensure the deficient	

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			practice will not recur, i.e., what quality assurance programs will be put in place? The Executive Director/Designee will audit the Fire Drill Documentation on a monthly basis, and will schedule additional drills, if warranted, to meet policy guidelines and ensure fire safety preparedness for the community. By what date will these systemic changes be implemented?9-27-12	

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R0121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			

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	Based on record review and interview, the facility failed to ensure new employees were given tuberculosis (TB) testing according to facility policy for 5 of 5 new employees reviewed for TB tests (Employee # 2, # 3, # 4, # 5, # 6). Findings include: A current facility policy, dated 4/1/1997, revised on 5/1/05 and titled "Tuberculosis Exposure Control Plan/Medical Screening - Associate" and provided by the Administrator on 8/29/12 at 11:00 A.M. indicated: "Policy Overview-- ... It is the intention of this program to promote a safe environment and to minimize the risk of occupational exposure to TB. Policy Detail--All associates who are determined at risk for occupational exposure to TB should be provided medical screening and surveillance. ... 4. The TB status of the associate should be completed using the two-step Mantoux skin test ... 5. The initial screening should be completed using the two-step Mantoux skin test ... Employee records were reviewed on 8/28/12 at 2:15 P.M., and the following new employees lacked documentation of 2nd step TB tests:	R0121	R 121 Personnel (Non-compliance) What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were cited as affected by the alleged non-compliant practice. Employees #2, #3, #4, #5, and #6 received notification of the need to initiate new 2 step mantoux testing immediately, and have been referred to the appropriate party to complete their testing. Employee #2, #3, #4, #5, and #6 were evaluated by a licensed nurse, using the community's existing TB Surveillance Form. None were found to have any symptoms associated with TB risk factors. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? The Administrative Assistant/HR Designee has been provided re-education on the Mantoux testing requirements for new and existing associates. The Administrative Assistant /HR Designee will audit the personnel records of existing associates for compliance with Mantoux Testing, and report findings to the Executive Director. Referrals will be made to the appropriate party to provide Mantoux Testing as indicated. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? A tickler file has been developed to document personnel and their Mantoux testing status.	09/27/2012

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	CNA # 2 hired 6/12/12, 1st step TB administered on 5/31/12 but the record lacked documentation of the 2nd step TB test given. CNA # 3 hired 6/12/12, 1st step TB administered on 7/31/12 but the record lacked documentation of the 2nd step TB test given. LPN # 4 hired 6/12/12, 1st step TB administered on 6/7/12 but the record lacked documentation of the 2nd step TB test give. QMA #5 (Qualified Medication Aide) hired 6/14/12, 1st step TB administered on 6/12/12 but the record lacked documentation of the 2nd step TB test given. CNA # 6 hired 6/14/12, 1st step TB administered on 6/11/12 but the record lacked documentation of the 2nd step TB test given. During an interview with the Administrator on 8/29/12 at 10:15 A.M., she indicated there wasn't any documentation for 2nd step TB tests for the new employees.		This tickler file will be updated monthly by the Administrative Assistant/Designee and a copy will be provided to the Executive Director on a monthly basis. The Administrative Assistant will notify associates of the timeframe for completion of Mantoux testing, according to existing guidelines and policy. In the event associates fail to complete testing as required, they will be removed from the schedule until they are in compliance. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? The Executive Director will audit a copy of the tickler file (to be provided by Administrative Assistant/HR Designee) on a monthly basis, and will make recommendations, corrective actions, as necessary, based on audit findings. By what date will these systemic changes be implemented? 9-27-12	

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R0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure dietary staff washed their hands when appropriate, disposed of outdated condiments, covered, dated, and labeled all items in the refrigerator, made sure a refrigerator vegetable bin was clean, and dishes were dry before stacking during 2 kitchen observations. This practice had the potential to affect 54 of 54 residents. Findings include: During observation of the 1st floor Servery (kitchenette) on 8/27/12 at 10:00 A.M., the refrigerator vegetable drawer was noted to have a dried dark substance at the bottom. Also noted was a squeeze bottle containing tartar sauce labeled "Do not use after 6/30/12." Present in the refrigerator door were other squeeze bottles. These included a container labeled "Italian," not to be used after 6/30/12. Three squeeze bottles were unlabeled as to contents, but there was a date of 8/23/12 noted on each container. During	R0273	R 273 Food and Nutrition Services (Deficiency) What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? The community makes every effort to be clean, orderly, and in a good state of repair, in order to provide a reasonable level of comfort for our residents. Kitchenette vegetable drawer has been cleaned Squeeze bottle contents were discarded and refilled with new contents. They have been labeled with expiration dates. Dining Services personnel will be check expiration dates daily and will remove any outdated items. Unlabeled/undated applesauce in bowl was discarded and replaced with properly labeled applesauce. Wet bowls on 3rd floor servery were taken to the main kitchen for appropriate sanitation/ Cook #1 was re-educated on appropriate handwashing and glove use procedures. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? The alleged deficient practice has the potential to affect all residents within the community. The Dietary Manager/Designee has provided re-education to dietary associates regarding Cleaning and	09/27/2012

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	an interview with the Executive Director on 8/27/12 at 10:30 A.M., she indicated the dates signified the date the substance was prepared and put in the container and it was good for 3 days after preparation and should have been discarded prior to 8/27/12. Also in the refrigerator was a small uncovered bowl, undated and unlabeled, which contained what appeared to be flavored applesauce. At 12:25 P.M., on 8/27/12, lunch observation in the 3rd floor Servery was started. Noted in an upper cabinet were 11 bowls stacked. Nine of the bowls had moisture in them, so much so they dripped when held sideways. During an interview with Cook #1, she indicated a dishwasher on the 1st floor hadn't been working the previous week, and the night shift had washed the dishes by hand and had stacked them wet, and they should have taken the dishes to the main kitchen and used that dishwasher instead. After partially unloading the food cart with the food prepared in the main kitchen into the Servery, Cook #1 prepared for the meal service by getting small bowls ready for the service. She placed small bowls onto a tray, took tossed salad in a plastic container, put on		Sanitation requirements, in order to provide them with guidelines for cleaning and sanitizing equipment, utensils and surfaces surrounding food preparation and storage areas. The Dietary Manager / Designee has provided re-education to dietary associates regarding proper hand washing and glove use policies, and will audit daily for compliance. The Dietary Manager / Designee will make audit each meal for hand washing compliance and will inspect food storage areas according to audit tool developed for this purpose. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? An audit tool will be utilized as a checklist for sanitation, cleaning, food storage, and hand washing practices. The designee will audit for compliance with each meal service. Results of audits will be kept in a binder designated as such, and will be available for review by the Executive Director, Dietary Manager/Designee as needed to monitor status. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? Audit results will be reviewed by the Executive Director/Designee on a weekly basis. The Executive Director will make recommendations for further quality review, based on results. Corrective action will be issued where indicated. This corrective action may include, but is not limited to, re-education, disciplinary action, and / or termination for non-compliance, based on the	

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	gloves, and with her gloved hand reached into the container and took handfuls of salad she then placed into the bowls. She removed her right glove, took a squeeze bottle and squirted salad dressing onto the salads in the bowls. She removed her left glove, picked up the tray, went into the dining room and served the salads to several residents. Cook #1 returned to the Servery, put on gloves, and put handfuls of salad into bowls, took off the gloves, and squirted a different dressing onto those salads. She again served salads in the dining room. On returning to the Servery, Cook #1 put on clean gloves, rubbed her left temple with the back of her left hand, and got utensils and plates from the cabinet and drawers to be ready to serve. Cook #1 put clean gloves on at that time, and scooped pureed meatloaf onto 2 plates. She then reached into the food cart and removed other food containers, then dipped more food for the plates. A few moments later, Cook #1 was observed reaching into a drawer, removed a knife, took bread from the bread package with her gloved hands, cut the bread and placed it onto plates, using her gloved hands. No hand washing was observed on the part of Cook #1 from the time the food cart was brought to the 3rd floor Servery		severity of the finding. By what date will these systemic changes be implemented? 9-27-12	

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	until the lunch observation ended at 1:00 P.M.. A current facility policy, dated May 2007, titled "Use of Gloves,"provided by the Executive Director on 8/28/12 at 9:10 A.M., indicated: "Process ... 1. Before putting the food handlers gloves on, hands must be washed according to hand washing policy...." A current facility policy, dated June 2002 and last revised December 2007, titled "How To: Hand Washing - Associates", provided by the Executive Director on 8/28/12 at 9:10 A.M., indicated: "Suggested guidelines: 1. Appropriate fifteen (15) to twenty (20) second hand washing should be performed in situations including but not limited to: ... Before touching, preparing, or serving food.... ... 3. The use of gloves does not replace hand washing. 4. Dining Services associates' hands should be washed at the kitchen sink upon entry into the kitchen...." During an interview with the Executive Director on 8/28/12 at 2:35 P.M., she indicated she had been in contact with the corporate office, and there was no other policy specific for dietary staff, when the current policy indicated "associate" it			

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	applied to all employees. A current facility policy, dated May 2007, provided by the Executive Director on 8/28/12 at 9:10 A.M., titled "Washing and Sanitizing Dishes...", indicated: "Description All dishes/utensils will be washed and sanitized using appropriate machine washing procedures.... ... 6. Air dry the dishes and utensils. Do not use towels for drying dishes/utensils, as this could contaminate the clean dishes/utensils...." The "Server Checkout List AM" and the "Server Checkout List PM" were provided by the Executive Director on 8/29/12 at 10:35 A.M. Included in the check lists were the following duties: For the A.M.: All dishes have been bussed, cleaned, and properly stored. The refrigerator has been wiped down and cleaned inside and out. All food in the refrigerator is labeled and dated. For the P.M.: All dishes have been bussed, cleaned, and properly stored. The refrigerator has been wiped down and cleaned inside and out. Al food in the refrigerator is labeled and dated.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0302	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, record review and interview, the facility failed to ensure over-the-counter (OTC) medications were labeled with the resident information according to the facility's policy for 1 of 3 medication carts observed. Findings include: A current facility policy dated 3/1/03, revised 7/1/10 and titled "Medications & Treatments -- Labeling Policy and provided by the Administrator on 8/29/12 at 10:15 A.M. indicated, "Policy Overview -- All medications and treatments (including over-the-counter and sample medications) should be labeled with the necessary information to provide safe medication management administration. Policy Detail--The label should be consistent with a physician's order and with applicable regulatory requirements. During observation of the medication carts on the 1st floor on 8/28/12 at 10:30 A.M., the med cart contained the	R0302	R 302 Pharmaceutical Services (Deficiency) What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? The nurse was unable to determine who provided these over-the-counter medications for storage in the medication cart. Resident families who provide over-the-counter medications will be compared to resident medication lists to determine appropriate ownership and provide appropriate labels for the three medications noted. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? The Charge Nurse /Designee will audit all medication carts for proper labeling of over-the-counter medications. Appropriate labels will be made available for nurses to affix on those over-the-counter medications brought in by families who do not utilize our preferred pharmacy for labeling. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? Licensed nurse will be provided	09/27/2012

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		A. BUILDING 00 B. WING	08/29/2012

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	following OTC medications without labels that identified the resident, physician's name, expiration date or the drug dosage: Nature Made Vitamin D3 2000 IU Spring Valley Vitamin B12 1000 mcg Natures Bounty Vitamin D3 1000 IU During an interview with the nurse on 8/28/12 at 10:30 A.M., she indicated she did not know who they belonged to so she wouldn't be able to administer those medications, "they are supposed to be labeled before being put in the medication cart."		re-education regarding our existing "Medication received from Families" policy as well as the existing policy for "Labeling Requirements for over-the-counter medications". This re-education will be provided by the Health and Wellness Director or Designee. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? Pharmacy consultant will audit for labeling compliance at each visit, at a minimum of every 60 days. Nurses will audit contents of medication carts with each med pass, and will utilize the labels provided for this purpose, or will document on the existing label, all required information. Results of medication labeling audits will be communicated to the Executive Director/Health and Wellness Director/Designee on a weekly basis. The Executive Director/Health and Wellness Director will take appropriate corrective actions, based on findings. Such action may include counseling, disciplinary action, up to and including termination of the associate responsible, in the event non-compliance is noted. By what date will these systemic changes be implemented? 9-27-12	

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R0306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record and interview, the facility failed to ensure medications were disposed of according to the facility policy for 1 of 3 records reviewed for disposition of drugs (Resident # 102). Findings include: A current facility policy, dated 11/2011 and titled, "Medication & Treatment -- Medication Disposal for Unused Controlled and Non-Controlled Medications" and provided by the Health and Wellness Director (HWD) indicated, "Policy Overview--Medication disposal should follow federal and state laws for all unused controlled and non-controlled medications ... Policy Detail--1. The	R0306	R 306 Pharmaceutical Services (Non-compliance) What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #102 was discharged from the community due to death. It is the policy of the community to properly dispose and document medication destructions following death. Nurses will be provided re-education regarding Medication Disposal policy as well as the documentation requirements for medication disposal. This training will be provided to nurses by the Health and Wellness Director/Designee. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? The Health and Wellness	09/27/2012

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	dispensing pharmacy should be notified and medications destroyed per individual Board of Pharmacy or state licensing agency regulation ... 3. Unused controlled and non-controlled medication may be disposed of in a blender, kitty litter, poured into plaster of paris mixture or as directed by the Divisional Director for Health Services and Quality (DDHSQ and then disposed of in the regular trash ...." The record for Resident # 102 was reviewed on 8/27/12 at 3:45 P.M. Diagnoses for Resident # 102 included but were not limited to cerebral vascular accident, peripheral vascular disease, non-Hodgkins lymphoma, depression, hypertension and tachycardia. The current physician's orders, originally dated 8/2/11, indicated a need for Risperidone 0.5 mg by mouth daily. The record lacked documentation of the disposition of the resperidone on discharge, which was 6/16/12. During an interview with the HWD (Health and Wellness Director) on 8/28/12 at 2:55 P.M., she indicated she could not find any documentation as to the dispostion of the medication resperidone.		Director/Designee will utilize an audit tool to assist with documentation requirements for discharged records. The Health and Wellness Director will notify the Executive Director with the results of these audits. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? Before any discharged record is officially closed, the Health and Wellness Director/Designee will be responsible for locating the Medication Destruction or Return to Pharmacy Form for these residents. A copy of one of these forms will be placed in the closed clinical record. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? The Health and Wellness Director/Designee will be responsible for audit of discharged residents prior to closing the medical record and placing in storage. The Executive Director/Designee will audit a sample of up to three discharged records per month in order to determine if additional quality review is needed, and will make additional recommendations based on audit results. Associates responsible for non-compliance with the above policies will receive corrective action, which may include re-education, counseling, and/or disciplinary action, at the discretion of the Executive Director. By what date will these systemic changes be implemented?	

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